AMERICAN ACADEMY OF PEDIATRICS

Committee on Pediatric Emergency Medicine

The Use of Physical Restraint Interventions for Children and Adolescents in the Acute Care Setting

ABSTRACT. This statement defines physical restraint and provides recommendations for its use in children and adolescents.

Children and adolescents may need to be physically or chemically restrained for various procedures, because of disruptive behavior, or to prevent injury to themselves or others. The use of restraint for a child or adolescent requires clear indications, safe application, reassessment guidelines, and use only after the consideration of alternative methods. *Seclusion* refers to the involuntary confinement of a patient alone in a room, from which the patient is physically prevented from leaving, for any period of time. The use of seclusion or restraint on children and adolescents hospitalized for psychiatric disorders has been reviewed by several authors and is beyond the scope of this statement.[1–4]

Restraints may be physical or chemical. Chemical restraint involves the use of psychotropic drugs or sedatives or paralytic agents. Physical restraint involves the use of physical or mechanical devices to restrain movement. Physical restraints may be cloth, leather, metal handcuffs or shackles, car seats, or seat belts. This statement is limited to the use of physical restraint in children and adolescents in the acute care or nonpsychiatric inpatient setting.

In the context of this statement, restraint differs from mechanisms that are usually and customarily used during transport or during diagnostic or surgical procedures. Common examples of these mechanisms in emergency department settings are a papoose board to aid in the control of a patient for the repair of a laceration or an arm restraint during the administration of intravenous fluids or medications.

Devices used to protect the patient, to support the patient in a specific position, or to assist in the maintenance of normal body functions are not considered restraint interventions. Examples of these types of devices are bed rails, tabletop chairs, and halter-type or soft-chest restraints.[5]

Situations that may require the short-term use of restraint in a child or adolescent include extreme, disruptive, self-injurious, or aggressive behavior as a result of drug intoxication, head injury, cerebrovascular hemorrhage, multiple trauma, or acute psychiatric disorder. Patients in status epilepticus may require short-term physical restraint to prevent injury to self or others until the seizure is controlled with antiepileptic agents. The use of the restraint, however, should not place a child or adolescent at risk of injury or deterioration of the medical condition.

The Joint Commission on Accreditation of Healthcare Organizations categorizes the use of restraint as a special treatment procedure requiring special justification for use. A physician's verbal or written time-limited order is obtained for each use. In addition, the standards require that hospital policy address the periodic observation of patients for whom restraint or seclusion is used.

Verbal interventions and therapeutic holding have been used for children and adolescents in psychiatric facilities to avoid the use of restraint or seclusion.[3,4,6] *Therapeutic holding* is the physical restraint of a child by at least two people to assist the child who has lost control of behavior to regain control of strong emotions. These techniques should also be considered as options for use in the acute care setting.

RECOMMENDATIONS

Policies for the use of physical restraint of children and adolescents in the acute care or inpatient setting should include the following:

1. An explanation to children why restraint is necessary, with the opportunity for children to respond to therapeutic holding when appropriate and safe.
2. A physician's written or verbal order specifying the type of restraint to be used and the importance of adequate restraint in relationship to its indication, with an estimate of duration. This order should be reviewed on an ongoing basis in the emergency department setting.
3. An immediate documented explanation to parents or family members as to why restraint is necessary.
4. An assessment according to hospital guidelines of those who have been restrained, assuring that the restraints are correctly applied, that skin integrity and neurovascular status remain intact, that restraints accomplish the purpose for which they were applied, and that the need for restraint continues.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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